

m VOLUME 4

REPORT NO. 1

(DOCUMENT SECTION)

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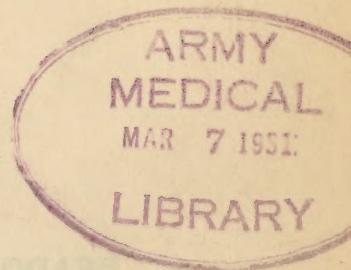
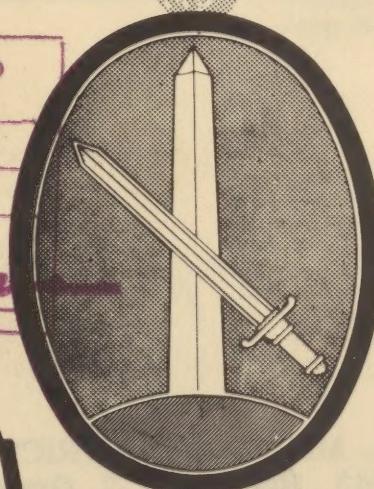
UNCLASSIFIED

MONTHLY HEALTH REPORT

U.S. Army.

Military District of Washington

CLASSIFICATION CHANGED	
TO	UNCLASSIFIED
AUTH	EO 10501
DATE	5 Nov 53
SECURITY OFFICER	
Frank B. Rogers	



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January 1951



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Room 1543, Building T-7, Gravelly Point
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INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as a basis for requisitioning supplies or equipment.

Contributions, as well as suggested topics for discussion, are solicited from Army Medical Service personnel in the field.

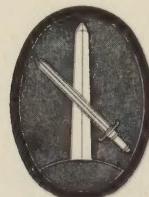
Robert E. Bitner

ROBERT E. BITNER
Colonel, MC
Surgeon



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PROFESSIONAL SERVICE

LIFE OF A DISPENSARY DOCTOR

By

Captain Edwin R. Priest, MC
Fort McNair Dispensary

I am impressed with the advantages of an Army medical practice. The full realization and appreciation of this service has developed after more than a year of active duty at an Army dispensary.

Prior to my entrance upon active duty with the Army Medical Service, I was a physician in a farming community located in the Northern Great Plains Area practicing general medicine. In this short article I desire to indicate some of the reasons why I have been impressed by medical care as practiced in the Army.

As a young physician, the most striking impression made upon me in my military medical service has been the availability of the modern diagnostic and therapeutic armamentarium needed for objective diagnosis. As a private practitioner I had been accustomed to thinking in terms of cost to the patient; cost of expensive laboratory tests, high cost of x-ray, and in some cases the prohibitive cost of therapeutic agents which I had wanted to prescribe. As a private physician I was of course vitally interested in the welfare of my patients, but I was compelled to continually weigh the cost of the medical service to the individual. In civilian practice it is not always easy to convince the patient unless he is very ill, that his health is more important than his money. In the Army one has no such distressing problem; the Army primarily considers the welfare of the patient and secondarily the cost.

The military physician has available to him large amounts of pharmaceutical supplies, laboratory facilities, roentgenographic services, and most important for the younger physician he can call upon specialists for consultation purposes. All these supplies, equipment and specialized services can be used as indicated in the study of a patient without regard to the economic level of the patient. The variety of drugs available through the Armed Forces medical supply is adequate in all but the rarest of illnesses; even in these cases, what is needed is procurable through special funds that have been set aside for the purchase of non-standard items of both medical equipment and drugs.

Contrary to civilian practice, there is never a concern over whether you can get your patient admitted to the hospital. If a hospital bed is needed, space will be made available in an Armed Forces medical hospital. Also the medical officer has access to both the hospital and his patient whom he may have hospitalized; there is no question as to whether there is space on the medical staff or whether his particular services are needed. The patient is accepted; the doctor is accepted.

My Army dispensary practice is not confined alone to military personnel. I see and treat the dependent population of military personnel in my area of medical service; consequently I have an opportunity to engage in general medical practice commensurate with a practice that I engaged in civilian life. The cases that I attend sometimes present baffling symptoms which makes it difficult to arrive at a definite diagnosis; they are not the standard textbook clinical pictures that are so often seen in civilian practice. This arises primarily because the military patient or his dependent is brought to my attention early in sickness, usually prior to the full development of the disease.

Individuals who are conscious of their health and not primarily concerned with the cost of medical attention arrive at the dispensary usually before the disease has progressed to its critical stages, thus preventive medicine, which is the essence of medical care, plays a major roll in the activities of the Army dispensary physician.

The Army doctor has an excellent opportunity to keep abreast of new medical developments. The regulated hours that he works, the allied medical personnel, both administrative and professional assigned to assist him, enable the medical officer to be free from the continual need to be available day and night. In civilian practice it was a rare evening when I could devote uninterrupted hours to study. Now I can make definite plans to attend medical meetings and can at my leisure devote a full evening to study.

Medical books and current medical journals are available to me, in my dispensary, and the Armed Forces maintains the largest medical library in the world. The facilities of this library are

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available to me, no matter where I might be stationed throughout the entire world. The librarian of the Armed Forces Medical Library will forward to me through the mail photostat copies of any clinical work I may be interested in studying. Other facilities of research and development in modern medicine are made available to me through the Armed Forces Institute of Pathology and the United States Army Medical Center.

Benefits other than those I have mentioned are more of a social nature but nevertheless are necessary to the full development of an individual regardless of the profession he may be engaged in.

To the young doctor embarking upon a military career are those fine friendships which are established with comrades in the Army. There is more of a sense of fellowship among doctors in the Army; a feeling of all being in the job together. The bitter rivalry found in civilian practice does not exist in the service. Only in passing will I mention the financial benefits of the Army career. The Army doctor does not have to send out bills at the end of the month or worry about the percent of collections. Neither are there those payments on the x-ray or diathermy apparatus falling due. The receptionist does not have to be paid by me either. Nor is there a monthly bill coming in for medicine.

It is not long until one realizes that the standard of Army medical care is as high as the individual doctor is willing to maintain it. I can maintain this standard at the highest level. I can devote my thoughts to the medical care of patients, without dividing them with the landlord, the laboratories, and the pharmaceutical houses, etc.

In an overall evaluation, I feel duly impressed with my Army medical practice, and I am conscious of the great roll the Army Medical Service is playing in the development of modern medicine.

* * * * *

DISPOSITION OF CLOTHING OF HOSPITALIZED PERSONNEL

Enlisted personnel hospitalized in US Army Hospitals frequently have lost a portion or all of their personal clothing through no fault of their own. Paragraph 23 of SR 32-20-1 dated 22 May 1950 prescribes procedures to prevent the loss of clothing.

When enlisted personnel are hospitalized at Class I hospitals, the hospital commander should advise the commander of the individual's unit that he has been placed in the hospital for medical treatment. The unit commander upon receipt of this notice should without delay cause the clothing of the individual to be inventoried and placed in safe keeping as outlined in paragraph 22 of the above Special Regulation.

When an individual is transferred from a Class I hospital to a Class II general type hospital irrespective of whether he is transferred to a medical holding detachment or whether he is carried by his unit as absent sick in hospital, the personal clothing of the enlisted man must in every case accompany him to the Class II hospital. The Class I hospital commander should advise the unit commander by the most expeditious means of pending transfers to the Class II hospital. When the unit commander receives this information he should cause the clothing of the individual to be taken direct to the Class I hospital where it is received for by the individual on the unit's retained copy of the Form 447. Should the individual's physical condition be such that he is unable to acknowledge receipt of the clothing, a designated officer, preferably the registrar, should acknowledge receipt of the clothing on the unit's retained copy of the Form 447. The designated officer (registrar) is responsible to make certain that the clothing does accompany the individual transferred from the Class I hospital to the Class II hospital. Every effort should be made to have this clothing accompany the patient upon transfer.

At times it will be physically impossible as a result of emergency circumstances for the individual's clothing to accompany him on a transfer to a Class II hospital, in those cases the unit commander within 24 hours after receipt of the information that the individual has been transferred will cause the clothing to be shipped to him at Government expense.

Every effort should be made by registrars, individual's unit commanders and individual enlisted personnel, to comply with the provisions of SR 32-20-1.

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MEDICAL EVALUATION OF THE NON-EFFECTIVE OFFICER

By

Colonel Albert J. Glass
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The recent campaign in Korea has brought into prominence the not infrequent practice of using medical facilities to remove non-effective officer personnel from their units. This does not refer to the disabled officer suffering from organic or psychiatric illness, but rather to those individuals who displace or blame their inability to perform stressful duty on to bodily or psychiatric symptoms. Such officers verbalize the normal disagreeable physical and psychial sensations of combat, which for them become exaggerated to an illness. They complain of backache, headache, insomnia, gastrointestinal disturbances, nervousness, and anxiety. Some frankly state that they cannot function in combat, but are excellent in other assignments. The non-effective officer is conspicuous by his failure to demonstrate the emotional stability and capability of a combat leader, and is in sharp contrast to the officer psychiatric casualty who has performed effectively in combat prior to a severe battle episode which caused his breakdown.

The basic cause of non-effectiveness in combat for any individual may vary from a conscious unwillingness to unconscious personality defects which prevent or limit his adjustability to any unusual or difficult situation. Almost anyone may become temporarily disorganized under severe stress, but soon the ability of the personality to adjust makes itself manifest and a learning process develops. Most non-effective officers are incapable of making the necessary adjustment and it is evident that such individuals do not possess the necessary qualities of a combat leader.

The medical officer is usually confronted with this problem because the non-effective officer either personally seeks medical evacuation or is sent to the medical officer by his immediate superior. Often in the heat of combat and with the necessary limitation of time a correct evaluation of such an individual cannot be made, and he must be further evacuated to the next medical echelon. Too often the individual continues to be evacuated even out of the theater of operations where his symptoms subside and he is returned to non-combat duty. Such hasty evacuation lowers the morale of officers who continue to perform their hazardous duties and gives the impression that failure is rewarded, with the implication that the Medical Department is responsible. A correct and fair solution of this problem would be to expedite a reasonable evaluation of such cases, preferably near the location of their origin. In combat divisions the medical officers of the Clearing Company, including the division psychiatrist, should be able to arrive at a correct diagnosis. For other units, nearby evacuation hospitals should be utilized. Only rarely should their be cases which require extensive duty and further evacuation.

In considering the diagnosis of non-effective officers primary importance should be given to motivation, previous military performance, and personality inventory of the subject. It is obvious that the officer who consciously displays poor motivation is not sick or disabled. The subject who has performed in a mediocre or indifferent manner in the past usually cannot be expected to do better under more stressful situations. There are many officers who have done good or excellent work in previous non-combat assignments. The personality of these non-effective officers reveal excessive basic insecurity which is compensated for by various character traits. Such individuals may be overly dependent, overly passive, overly cautious, or overly aggressive. These character traits may serve them well in most routine jobs, but in combat or other unusual circumstances the neurotic defense against fear fails and because they have not further resources they become overwhelmed with anxiety and are literally incapable of effective action.

The duty of the medical officer in the case of the ineffective officer is clear and unequivocal. If, after evaluation, the medical officer can find no disabling organic or psychiatric disease the officer must be returned to duty. The diagnosis may be, "No disease, poor motivation", or any of the character or behaviour disorders as outlined in SR 40-1015-2. A copy of the findings should be sent to the patient's unit commander. The further handling or disposition of the non-effective officer should be along administrative lines under the provisions of AR 605-200. This regulation provides for the separation, demotion, or elimination of non-effective officer personnel. Pertinent excerpts from paragraph 4 of AR 605-200, stating the reasons for the utilization of this regulation are as follows:

"Demonstrated inability to exercise the necessary leadership or command required of an officer of his grade."

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"Habitual intemperance or recurrent instances of other personal misconduct."

"Apathy, defective attitudes, or other character and behavior disorders to include inability or unwillingness to expend effort. Attention is directed to SR 40-1025-2."

This may seem to be a harsh policy but in reality it only corrects an administrative error. No one is forced to accept a commission and when an officer does not possess the required qualifications, corrective, not punitive, measures are indicated. There may be instances where the medical officer may be urged to evacuate non-effective officers under the guise that there is not time for administrative action, or a replacement is immediately needed, or a feeling of pity for the individual. It is important to note that the morale and the very lives of soldiers depend upon the effectiveness of their officers. The medical officer should resist such pressure since the perpetuation of a group of ineffective officers is a serious mistake.

What has been stated above applies with equal force to routine military practice, whether it be in occupation duties or in the zone of the interior. Many officers promptly break down after overseas assignment or when sent to some less desirable post. Here too they show limited ability to adjust to a relatively mild environmental discomfort. This maladjustment may be manifested by symptoms, excess alcoholism, or acts of misconduct. Where no disease is present such cases properly come under administrative procedure, as outlined in AR 605-200 rather than handling through medical channels. The non-effective officer cannot be considered ill since he loses all symptoms when the external situation is altered to his satisfaction. It is rather an immature reaction to adult responsibility. It may well be that transfer to another assignment or location is indicated, but this is an administrative and not a medical matter.

CONCLUSION: A most important factor affecting the fighting strength of our armed forces resides in the effectiveness of our officer personnel. Non-effective officers who are not disabled by organic or psychiatric disease, but who do not possess motivation or qualities required by an officer should not be removed from their units via medical facilities. It is the function of the medical officer to insist that such non-effective officer personnel be handled through administrative channels, under provisions of AR 605-200.

(The above article is from Medical Section, General Headquarters, Far East Command, Vol. V, No. II, dated 11 Nov 1950)

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INDUSTRIAL HYGIENE

The following is a guide based upon AFR 160-67 dated 18 December 1950 for use by installations in requesting surveys from the Army Environmental Health Laboratory at Edgewood Arsenal, Maryland. See AR 40-220.

1. Command or installation requesting services.
2. Agency familiar with problem
3. Description of operation or process and problem.
 - a. Technical Orders applicable:
 - (1) Deviations.
 - (2) Reason for deviations.
 - b. Photographs and/or blueprints (if available).
4. Materials used in process:
 - a. Specification number
 - b. Stock number.
 - c. Approximate amount used each day.
5. Number of people exposed each day:
 - a. Male.
 - b. Female.
 - c. Approximate hours exposed each day.
6. Dimensions of room or building in which operations are conducted:
 - a. Number and size of windows, doors, and skylights.
 - b. Description of other operations in immediate vicinity.
7. Control measures in effect:
 - a. Ventilation (type)
 - b. Personal protective equipment (type)
 - c. Isolation from other operations.
8. Efforts made to control the hazard:
 - a. Description.
 - b. Effectiveness.
9. Personnel affected by exposure:
 - a. Number.
 - b. Major complaints
 - c. Pathology noted by examining physician.
10. Remarks

PROFESSIONAL SERVICE

ARMY DEVELOPS PERFECT SUBSTITUTE FOR MORPHINE

Perfection of a new synthetic narcotic to replace morphine was announced recently by Dr. Henry K. Beecher, civilian consultant to the Army Surgeon General. Dr. Beecher is Professor of Research in Anesthesia at the Medical School of Harvard University and Chief of the Department of Anesthesia at Massachusetts General Hospital.

Just arrived from Korea where the new drug, methadone, was tested at the farthest forward evacuation hospital near Hamhung on hundreds of American and allied wounded, Dr. Beecher declared that the field tests verified the findings that have been made in thousands of postoperative cases during the last three years at Massachusetts General Hospital.

The story of methadone goes back to the day in 1945 when the Army took over the I.G. Farben-plant in Germany. Preliminary work had been done there and the information turned over to the Research and Development Board of Army Medical Service. During the postwar years the Surgeon General's Office has worked closely with other interested groups to perfect the new synthetic which has the same effect as morphine, milligram for milligram, and which is made from nitriles derived from nitrogen and hydrocarbons.

Final validation has been made under the most rigid conditions and methadone can be used either as a substitute or interchangeable with morphine. The racemic form of methadone is now on the market and is being made by several manufacturers for the government. The form known as Levo-Iso is the best to date.

An interesting sidelight is that methadone may be less habit forming and will probably be a great help in curing morphine addicts. Tests at the U.S. Public Health Service for addicts at Lexington, Kentucky, showed the drugs relieve the terrible sufferings of patients being taken off morphine.

While the pain killing power is as great as that of morphine its side effects are even better since Levo-Iso produces far less nausea and vomiting. It has the same effect in depressing respiration as does morphine. While generally administered subcutaneously, it may be given intravenously or by mouth.

The Army operates under the most exacting and variable conditions throughout the world. Accordingly, before making a final appraisal of methadone it was felt that the ultimate test lay in using it in the most demanding environment we ever expect to encounter. Actually, two field tests were made in the Far East, one by three doctors at Tokyo Army Hospital who administered methadone on a round-the-clock basis; the other by Dr. Beecher himself at the evacuation hospital near Hamhung. In the field it was used preoperatively in from minutes to hours of the time men were wounded. One major objective of the Korean field tests was to see whether it would stand up under the stress and strain of abnormal conditions. It did, even when the temperature was 27 degrees below zero. Methadone has the same rapidity and duration of effect as morphine.

At the Anzio beachhead where he spent 75 days, Dr. Beecher found that men with severe wounds are not always in pain. The reason for this, he said, is that emotion can block pain. He further stated that only one-fourth of seriously wounded men feel enough pain to want a pain-relieving drug.

The new discovery makes the United States quite independent of foreign opium markets of Asia and the Near East.

SGO DEPARTMENT OF ARMY RELEASE - 5 JANUARY 1951

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"The true practitioner must not be too disinterested, too mechanical, nor too academic, and he must have a soul". F. H. Martin, M. D. in "Fifty Years of Medicine and Surgery".

"Scientific medicine, being founded on demonstrable truths, must in the end maintain itself and secure the confidence of the people". General Sternberg Address to AMA 1898

"Work is the integral part of the life of the normal man and woman". Paul D. White, M.D.

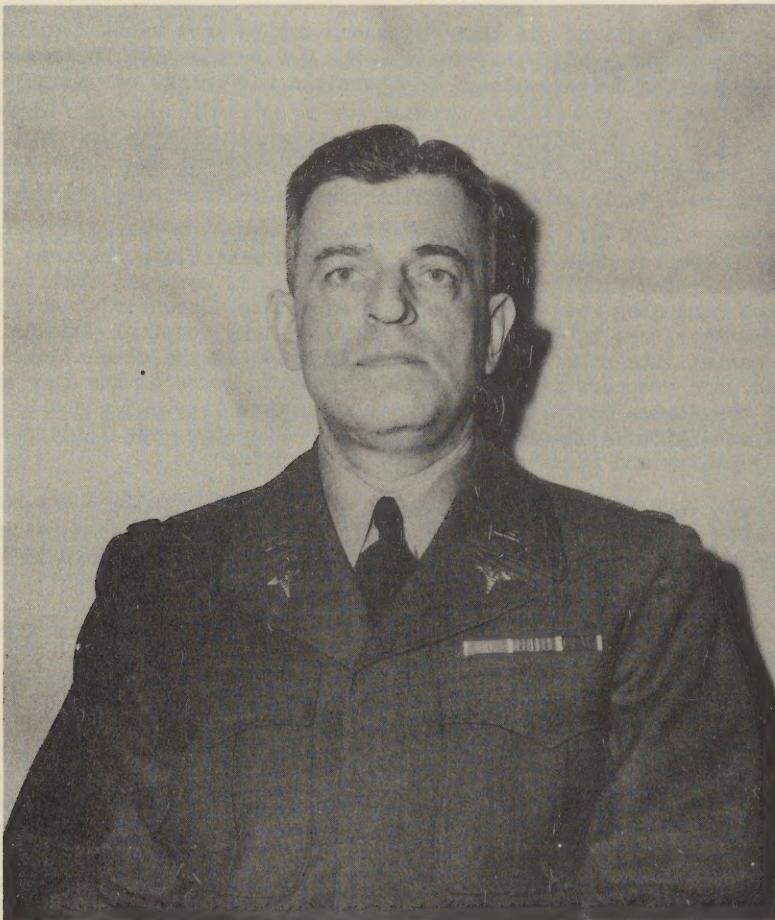
PROFESSIONAL SERVICE

NEW COMMANDING OFFICER OF THE US ARMY HOSPITAL, FORT BELVOIR, VA.

Colonel Frederick B. Westervelt has been named Post Surgeon and Commanding Officer of the US Army Hospital at Fort Belvoir, Virginia. The new Post Surgeon assumed his duties on 5 January 1951.

Colonel Westervelt was born in Pittsburgh, Pennsylvania on 31 July 1903 and was graduated from the University of Pittsburgh in 1925 with an A. B. degree and received his medical degree from the University of Pittsburgh in 1930. Upon graduation from the University of Pittsburgh in 1925 he received a reserve Infantry commission. His active duty started with internship at Walter Reed Army Hospital in 1930. He attended the Army Medical School in 1932, Medical Field Service School in 1933 and remained at Carlisle Barracks until 1937 during which time he was assigned to the 1st Medical Regiment.

Colonel Westervelt is a graduate of the Command and General Staff College of 1938 and the Army-Navy Staff College of 1943. During World War II he was overseas on the staff of Admiral Nimitz at Pearl Harbor and then was appointed Tenth Army Surgeon until the Army was deactivated at the end of the war. He then spent a short period as Medical Inspector for AFWESPA. After return from overseas, Colonel Westervelt spent a short tour at Brooke Army Medical Center followed by two and one-half years in the Surgeon General's Office and since September 1949 has been with the Army Personnel Board of the Secretary of the Army in Washington, D. C.



DENTAL SERVICE

ARMY DENTAL SERVICE

Although the dental service participates in the mission and general functions of the Medical Service it has become such a highly specialized service as to require dental officers to be placed on the staffs of commanders. Army Regulations 40-15, dated 27 September 1948, state: "In a major command, army division, or other headquarters, including installations, matters relating to the dental service are administered by the dental surgeon of the command. He is responsible directly to the commanding general/officer for all professional, technical, and administrative matters pertaining to the dental health of the command." This regulation further states: "There will normally be a staff dental officer for each major command, or installation. Normally, the senior dental officer present for duty with the command or installation will, in addition to his other duties, be the staff dental officer. The basic title as a staff dental officer will be "Dental Surgeon" which, as commonly used in military service indicates a staff or advisory position rather than a professional qualification, and is analogous to such terms and positions as quartermaster, adjutant, etc."

General policies concerning the Medical Service emanate from The Surgeon General's Office, wherein there is a Dental Division, and matters relating to the dental service of the Army are administered by the Chief of the Dental Division. He is responsible for making recommendations on all matters relating to the dental health of the Army, and for supervising the execution of approved plans pertaining to the dental health of the Army and for the progressive development of the dental service. With the Chief of Dental Division, in The Surgeon General's Office, and dental surgeons on the staffs of commanders of the various echelons of commands, an echeloned supervision and administration of the dental services by dental personnel is formed.

DUTIES OF THE DENTAL SURGEON

The staff dental surgeon is responsible for the preparation of plans and policies for the progressive development of the dental service, with special reference to the preservation of the general health of the command by the prevention, treatment, and control of dento-oral diseases, injuries and deficiencies of all military personnel under the jurisdiction of the headquarters to which assigned. He advises the surgeon in all matters that may have a bearing on the health of the command from a dental standpoint. Specifically, his duties included the following:

- (1) Advise the commanding general/officer of the requirements for enlisted and civilian personnel in the Medical Service (dental service); to make recommendations concerning their promotion and reduction, and concerning the ratings and disratings of dental technicians.
- (2) Recommend to the commanding general/officer the requirements of commissioned dental personnel, and to recommend their assignment to positions and duties they are best qualified to fill.
- (3) Keep the medical supply officer informed as to the needs of the dental service as regards dental supplies and equipment.
- (4) Recommend to the commanding general/officer appropriate action with respect to the construction and repair of buildings required for dental clinics; take appropriate action on supplies purchased for, or services rendered to the Medical Department, and inspections involving the dental service.
- (5) Recommend to the commanding general/officer the issue at proper times of orders containing specific instructions regarding the dental service.
- (6) Familiarize himself thoroughly with the amount of character of all dental equipment of the command.
- (7) Recommend to the commanding general/officer plans and programs for the instruction and training of dental personnel.
- (8) Prepare an annual report of the dental activities of the command, which will be forwarded to arrive in the Office of The Surgeon General not later than 1 March of the following calendar year.

DENTAL SERVICE

(9) Provide the surgeon of the command with an information copy of any reports of communications reflecting the dental health of the command.

(10) Render efficiency reports on dental officers under his supervision as provided in AR 600-185, and initiate recommendations for promotion under current directives.

The above duties may be classified as administrative, advisory, supervisory, and coordinate.

(1) Administrative duties are those which involve the internal administration of the dental section of a major headquarters. They include:

(a) Initiating or consolidating, and forwarding all required dental records, reports and data.

(b) Initiating and conducting correspondence relating to the dental service.

(c) Recording qualification data in reference to dental personnel.

(d) Tabulations as to accomplishment and efficiency of the dental services of subordinate units.

(e) Tabulations as to dental status of subordinate units as revealed by routine or special reports.

(f) Prepare data as a basis for recommendations in reference to the dental service.

(g) Study equipment lists, tables of equipment, and tables of organization in references to adequacy.

(h) Prepare statistical data in reference to the dental service.

(2) Advisory duties consist of the furnishing of advice and recommendations to the commanding general/officer in reference to the dental service. Advisory duties are generally follow-up action based upon administrative duties, such as recommendations for augmentation of equipment lists, following an administrative study which indicated an inadequacy of supplies or equipment. Advisory duties include the furnishing of advice and recommendations to the commander regarding:

(a) Procurement and assignment of dental personnel.

(b) Procurement and distribution of dental supplies and equipment.

(c) Plans and programs for the instruction of dental personnel.

(d) Morale of dental personnel.

(e) Standardization of professional and technical procedures when and if considered necessary.

(f) Issuances of directives containing specific instructions regarding the dental service.

(g) Essential construction for dental activities.

(h) Utilization of existing facilities or structures.

(i) Plans for meeting special situations as they arise.

(j) All matters not enumerated that have a bearing on the dental service.

(3) Supervisory duties include:

DENTAL SERVICE

(a) The making of frequent inspection of the various dental activities of a command to determine the:

1. Efficiency of each service.
2. Cleanliness, orderliness, and sanitation.
3. Adequacy of equipment and supplies.
4. Morale of dental personnel.
5. Adequacy and correctness of records.
6. Quality of service rendered.
7. Problems of each particular service.
8. Adequacy of space and facilities allotted to the dental service.
9. Care and supervision of supplies and equipment.

(b) To take indicated action in case of deficiencies noted.

(4) Coordinative duties include:

(a) The organization and operation of the dental service or services of the command to the end that the maximum of service is rendered with the minimum of interference with other essential services.

(b) Regulating the dental care of units which have no assigned dental personnel, to provide an equitable distribution to the various establishments dental services.

(c) Coordinating with other staff sections the plans for the establishment of dental services in new operations, and for the regulated flow of dental supplies and equipment in support of such operations.

Reference - Medical Battalion, page 5, Volume 3, Report No. 11, November 1950 issue, regarding Dental Officers is amended to read: "The Dental Section of the Headquarters and Headquarters Company Medical Battalion comprises 18 Dental Officers: 1 Major DC, SSN 3178, also division dental surgeon; 1 Major DC, SSN 3175, Prosthodontist; 16 Captains or 1st Lieutenants SSN 3170, Dental Officers. Reference T/O & E 8-16N, 27 February 1948.

SOME TIPS ON CONDUCT OVERSEAS

Remember you are a personal representative of your country.

Behave yourself as well as you would at home.

Respect your Ally as a man.

Show particular respect for an Ally's women and old people.

Determine the customs of your Ally and respect them.

Use judgment in spending your money.

Don't brag.

Don't criticise the political system or religion of an Ally.

Don't judge an Ally by his plumbing.

Don't drink more liquor than you can handle.

Don't abuse an Ally's hospitality.

Don't criticize an Ally's efforts in the common fight.

(Above is from D/A Pamphlet No. 20-130, Army Troop Information Discussion Topics, "Getting Along With Our Allies")

PREVENTIVE MEDICINE

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GENERAL COMMENT

The health of the command continued to be excellent.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and Class II installations exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army Medical Service installations do not include Air Force personnel. (See General Data and Admissions Tables on page 11).

The non-effective rate* increased from the November rate of 15.20 to 16.69 for the month of December. Days lost as a result of disease and injury totaled 14,383 during the five week period ending 29 December 1950.

$$\begin{aligned} \text{*Non-Effective Rate} = & \frac{\text{Total Days lost} \times 1,000}{\text{No. of Days} \times \text{Average Daily} \\ & \quad \text{in Period} \quad \text{Strength}} \end{aligned}$$

Non-effective rates indicate the average number of patients in hospital or quarters per thousand mean strength during the report period.

The total admission rate** for disease and injury in December was 675.1, compared to 534.8 during November. Total admission for disease and injury in December was 1594. Of this number, 1415 admissions were for disease and 179 injuries. Fort Myer reported the highest admission rate, and all others reported the lowest rate during the current month.

$$\begin{aligned} \text{**Admission Rates} = & \frac{1,000 \times 365 \times \text{Number of Cases}}{\text{Mean Strength} \times \text{No. of Days in Period}} \end{aligned}$$

Admission rates show the number of cases per thousand strength that would occur during a year if cases occurred throughout the year at the same rate as in the report period.

December's rate for disease cases is 599.3 for 1415 cases. Fort Myer reported the highest admission rate, and All Others, reported the lowest rate for disease cases.

An injury admission rate of 75.8 per 1,000 per annum for December was reported. This was an increase from the November rate of 51.1. Fort Belvoir reported the highest rate and US Army Dispensary, The Pentagon reported the lowest rate for injuries.

There were 3 deaths reported during the five week period ending 29 December 1950, by units within the Military District of Washington less Walter Reed Army Hospital.

COMMUNICABLE DISEASE

Common respiratory diseases increased in incidence during the month of December, 1950. The rate for the present month is 253.2 compared to the November rate of 149.3. Fort Myer reported the highest rate, and South Post, Fort Myer, reported the lowest rate. Admission rates for pneumonia (all types) decreased during the December report period. The rate being 13.9 compared with the November rate of 14.7. There were no cases of scarlet fever reported throughout the month of December.

No appreciable change was noted in the rate for mumps, tuberculosis, rheumatic fever, diarrhoeal disease, and hepatitis during the five week period ending 29 December 1950.

Pertinent statistical tables may be found on pages 12 and 16.

PREVENTIVE MEDICINE

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GENERAL DATA
5-Week Period Ending 29 December 1950
(Data from WD AGO Form 8-122)

STATION	MEAN STRENGTH			DIRECT ADMISSIONS						Non-Effective Rate	Number of Deaths
	Total	White	Negro	All Causes		Disease		Injuries			
				Cases	Rates	Cases	Rates	Cases	Rates		
Fort Belvoir, Va.	14661	13077	1584	1140	810.85	998	709.85	142	101.00	20.17	3
Fort McNair, Wash DC	792	725	67	48	632.00	41	539.83	7	92.17	11.99	0
Fort Myer, Va.	1866	1694	172	184	1027.72	167	932.77	17	94.95	17.23	0
So Post, Fort Myer, Va.	2081	2064	17	105	526.16	99	496.09	6	30.07	11.09	0
US Army Disp. The Pentagon	3619	3591	28	93	267.98	89	256.45	4	11.53	12.66	0
All Other	1601	1598	3	24	156.32	21	136.78	3	19.54	3.89	0
Total-Military District of Washington	24620	22749	1871	1594	675.15	1415	599.33	179	75.82	16.69	3
AMC - Med Det (Duty Pers)*	1494	1386	108	38	265.20	36	251.30	2	13.90	8.10	0

*Army and Air Force Personnel Included

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR
5-week Period Ending 29 December 1950
(Data from WD AGO Form 8-122)

STATION	Common Respiratory Disease	Pneumonia All Types	Pneumonia Atypical	Influenza	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Diarrheal Disease	Hepatitis	Malaria	Psychiatric Disease
Fort Belvoir, Va.	138.17	21.34	10.67	5.69	44.81	9.96	-	-	4.98	-	1.42	1.42	12.09
Fort McNair, Wash. D. C.	263.33	-	-	-	-	-	-	-	-	-	-	-	-
Fort Myer, Va.	402.15	-	-	-	-	-	-	-	-	16.76	-	-	-
So Post, Fort Myer, Va.	85.19	5.01	5.01	10.02	5.01	-	-	-	-	-	5.01	-	-
US Army Dispensary, The Pentagon	126.78	5.76	5.76	-	-	-	-	-	-	2.88	2.88	-	-
All Others	-	-	-	-	-	-	-	-	-	-	-	-	-
Total-Military District of Washington	253.21	13.98	7.62	4.24	27.11	5.93	-	-	2.96	1.69	1.69	.85	7.20
AMC-Med Det (Duty Pers)*	6.70	20.10	-	-	-	6.70	-	-	-	-	-	-	-

*Army and Air Force Personnel Included

* * * * *

ARMY MEDICAL SERVICE IN THE FAR EAST

"1. The following Memorandum directed to The Surgeon General is quoted for your information:

"1. I have read your report on the performance of the Army Medical Service in the Far East and note with particular pleasure the fine achievement of medical personnel in their professional field. The impressive record obtained in life-saving efforts and attainment of extremely low incidence of disease in Korea is one which merits the highest praise.

"2. I desire that you transmit to all personnel of the Medical Service my sincerest appreciation of a superior accomplishment in the field of military medicine.

Frank Pace, Jr.
Secretary of the Army'

"2. The Surgeon General desires to add his appreciation to that of the Secretary of the Army.

"BY COMMAND OF MAJOR GENERAL BLISS:

S/ T. J. Hartford
T. J. HARTFORD
Colonel, M.C.
Executive Officer"

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VENEREAL DISEASE

Venereal Disease rate among units within the Military District of Washington, decreased during the December report period.

The rate for December 1950, was 12.71 decreased from the November rate of 14.76. A total of 30 cases were reported for the five week period ending 29 December 1950. Of this total 28 were reported by Fort Belvoir, 1 for Fort Myer, and 1 for All Others.

During the report period, white personnel incurred 21 of the reported number of cases, with a rate of 9.63 and 9 were incurred by negro personnel, with a resulting rate of 50.16 per 1000 troops per annum.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (December) in addition to the rate per 1000 per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 14, 15 and 16.

NEW VENEREAL DISEASE CASES - EXCL EPTS - OCTOBER, NOVEMBER AND DECEMBER 1950

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	OCTOBER 50	NOVEMBER 50	DECEMBER 50	DECEMBER 50
Fort Belvoir	16.06	22.93	19.92	1.909
Fort McNair	-	-	-	-
Fort Myer	-	-	5.59	.535
South Post, Fort Myer	7.64	13.33	-	-
U.S. Army Dispensary, Pentagon	-	-	-	-
All Others	14.24	7.45	6.51	.624
Total - Military District of Washington Units	10.53	14.76	12.71	1.218
Army Medical Center - Medical and Holding Detachments	4.66	-	-	-
Total - Dept/Army Units Mil Dist of Washington	9.84	13.11	11.29	1.082

* * * * *

Metropolitan Life Insurance Company Statistical Studies based on report from the National Office of Vital Statistics for the period 1934 - 1947 show:

Twins occur once in every 92 births.

Triplets occur once in every 9400 births.

Quadruplets occur once in every 620,000 births.

Quintuplets very remote; two authentic cases of living quintuplets are on record: The Dionne of Canada and Diligentis of Argentina.

* * * * *

PREVENTIVE MEDICINE

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CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY MDW RATE PER 1000 TROOPS PER YEAR

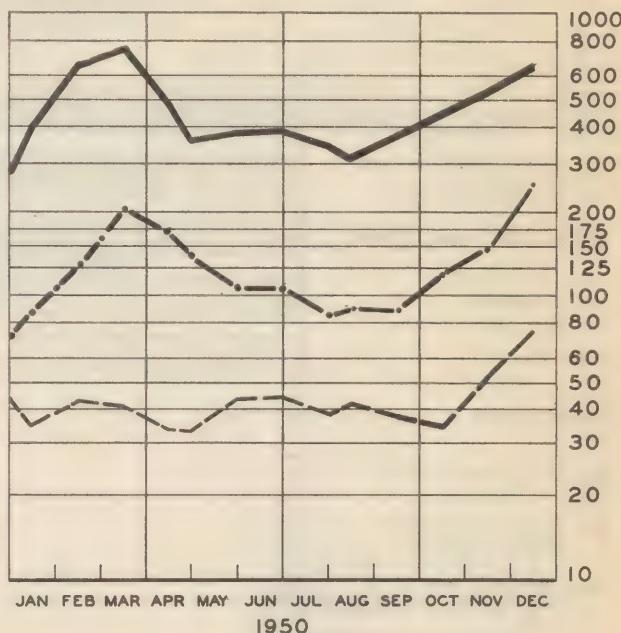
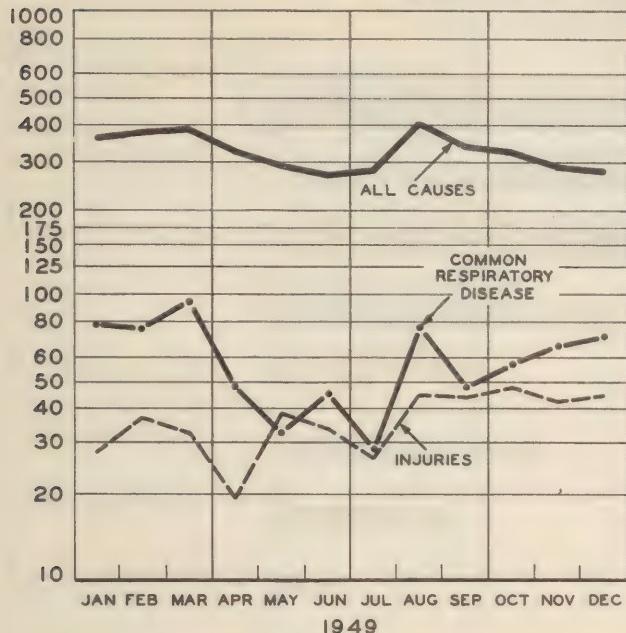
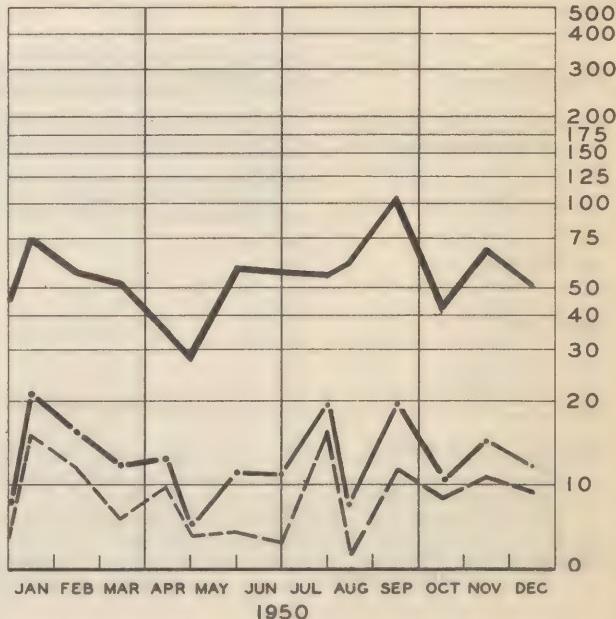
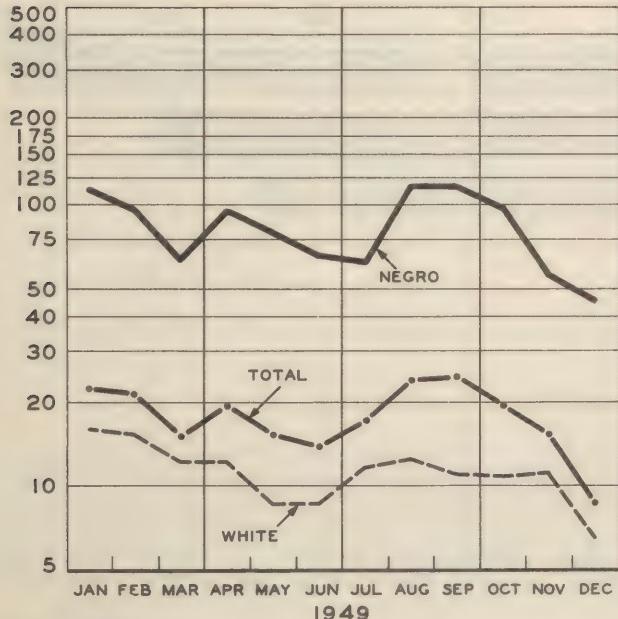


CHART 2

ADMISSION RATES BY MONTH VENEREAL DISEASES MDW NOT INCL. ARMY MEDICAL CENTER RATES PER 1000 TROOPS PER YEAR

INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS

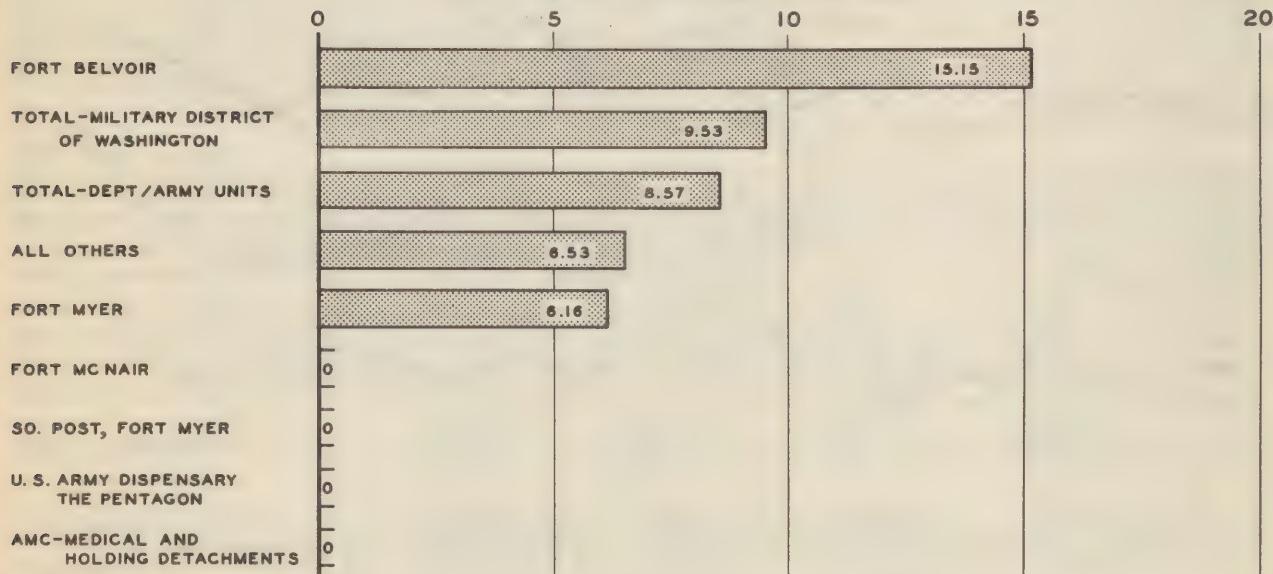


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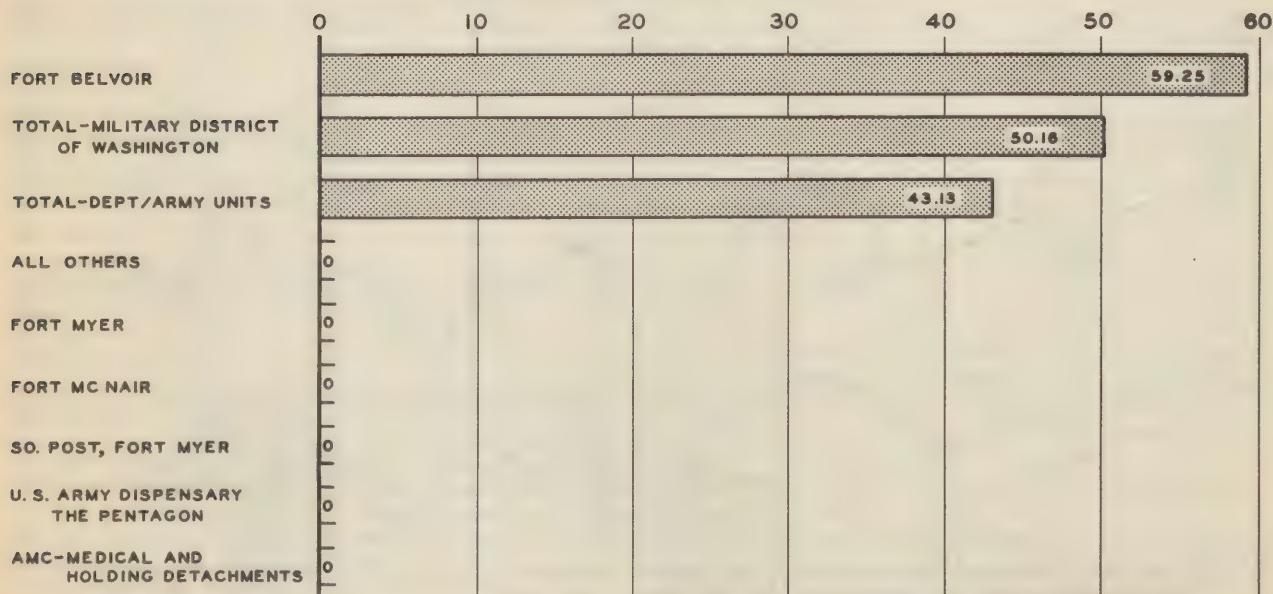
PREVENTIVE MEDICINE

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VENERAL DISEASE RATE PER 1000 TROOPS PER YEAR 5 WEEK PERIOD ENDING 29 DEC 1950 WHITE PERSONNEL (CHARGEABLE CASES)



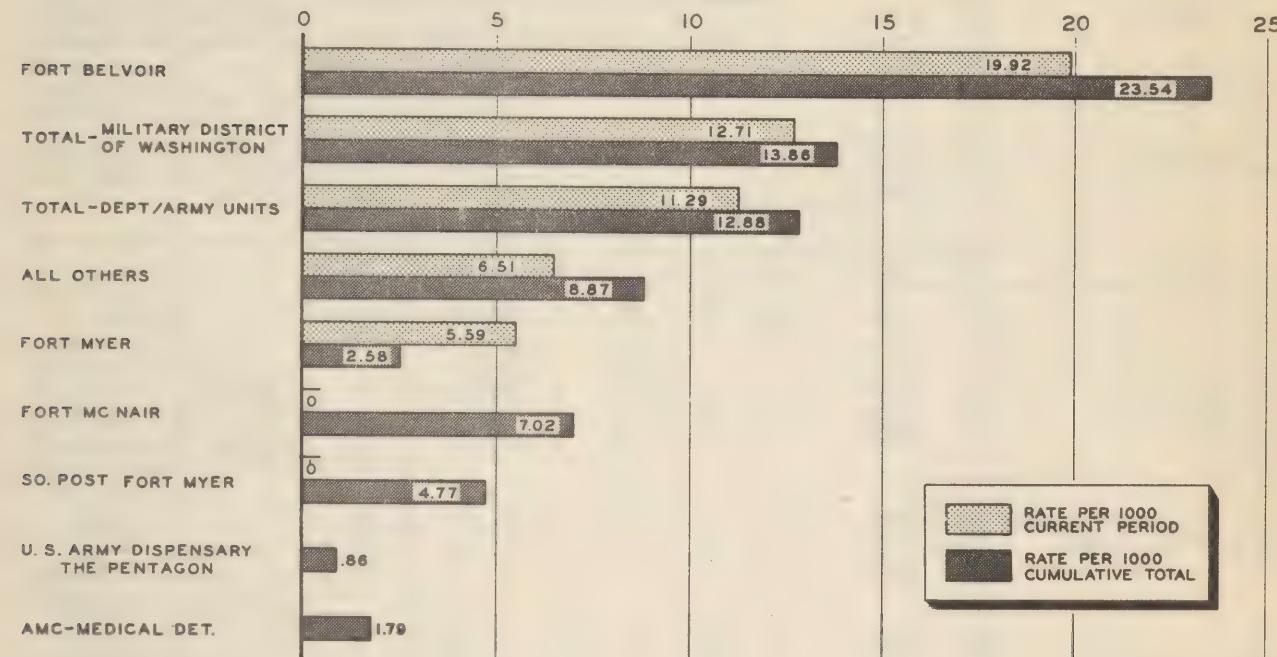
VENERAL DISEASE RATE PER 1000 TROOPS PER YEAR 5 WEEK PERIOD ENDING 29 DEC 1950 NEGRO PERSONNEL (CHARGEABLE CASES)



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**VENEREAL DISEASE
RATES PER 1000 PER YEAR
FIVE WEEK & CUMULATIVE TOTALS ENDING 29 DECEMBER 1950
TOTAL WHITE & NEGRO PERSONNEL
(CHARGEABLE CASES)**



VENEREAL DISEASE RATES FOR US*

(All Army Troops)

	OCTOBER 1950	NOVEMBER 1950	DECEMBER 1950
First Army Area	14	14	15
Second Army Area	25	17	20
Military District of Washington	10	13	11
Third Army Area	23	24	21
Fourth Army Area	17	22	25
Fifth Army Area	14	13	8
Sixth Army Area	18	15	17
TOTAL United States	19	17	18

*Compiled in the Office of the Surgeon General and includes U.S. Army Hospitals.

AN ASSISTANT BATTALION SURGEON IN KOREA

The following quotes from a letter written by an Assistant Battalion Surgeon who is assigned to the Second Division appeared in the Training ORC Bulletin, published by the Medical Field Service School: "Impress upon all personnel that they must not drink any water from any source whatsoever until it has been properly chlorinated. They must not eat any native food. A large percentage of our noneffectives have come from those people who are neglecting these precautions. The TB MED on Korea is excellent and should be impressed upon everyone. This would help a lot in cutting down our sick rate. I tried to tell my men about the filth and dirt, flies, mosquitoes, and so forth, but it is difficult for the average American to realize these things. There just isn't any sanitation in Korea."

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CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT
For the Five Week Period Ending 29 December 1950
(Data from WD AGO 8-122) (Chargeable Cases)

STATION	R A C E	Mean Strength	Number of Cases-EPTS Not Included				Rate per 1000 Troops per Annum	Total Days Lost From Duty(Old & New Cases)
			Syphilis	Gonorrhea	Other	Total		
Fort Belvoir	W	13077	1	18	0	19	15.15	7
	N	1584	1	8	0	9	59.25	0
	T	15661	2	26	0	28	19.92	7
Fort McNair	W	725	0	0	0	0	-	0
	N	67	0	0	0	0	-	0
	T	792	0	0	0	0	-	0
Fort Myer	W	1694	0	1	0	1	6.16	0
	N	173	0	0	0	0	-	0
	T	1866	0	1	0	1	5.59	0
South Post, Ft Myer	W	2064	0	0	0	0	-	0
	N	17	0	0	0	0	-	0
	T	2081	0	0	0	0	-	0
US Army, Dispensary The Pentagon	W	3591	0	0	0	0	-	0
	N	28	0	0	0	0	-	0
	T	3619	0	0	0	0	-	0
All Others	W	1598	0	1	0	1	6.53	0
	N	3	0	0	0	0	-	0
	T	1601	0	1	0	1	6.51	0
Total-Military District of Washington	W	22749	1	20	0	21	9.63	7
	N	1871	1	8	0	9	50.16	0
	T	24620	2	28	0	30	12.71	7
Army Medical Center	W	2791	0	0	0	0	-	0
	N	305	0	0	0	0	-	0
	T	3096	0	0	0	0	-	0
Total-Dept/Army Units	W	25540	1	20	0	21	8.57	7
	N	2176	1	8	0	9	43.13	0
	T	27716	2	28	0	30	11.29	7

"Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

--Constitution of the World Health Organization

DENTAL SERVICE

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DENTAL SERVICE - FIVE WEEK, PERIOD ENDING 29 December 1950

STATION	Military	Civilian	Oxy	Amal	Amal	In-	Bridge	Dentures			Calcu	X-Rays	Examina-			
	Men Duty	Men Duty	Sit- tings	gum	and Sili-	lays	Bridges	Repair	Crowns	Par- full	Re- pair	Extrac-	tions	Removed	lus	1091
Fort Belvoir	10 310	1 20	3832	351	320	136	0	9	16	6	16	17	19	673	190	1030
Fort McNair	3 59	0 0	301	122	60	38	2	1	2	1	3	9	6	29	23	152
Fort Myer, Va.	3 93	0 0	1011	408	55	61	1	1	3	5	1	7	12	76	8	486
South Post Ft Myer	1 23	1 20	330	175	100	24	0	0	0	0	2	5	2	19	6	71
US Army Disp. The Pentagon	6 170	0 0	1870	343	151	97	5	0	3	4	7	15	10	93	212	748
All Others	2 51	0 0	334	152	51	28	0	1	0	1	0	7	3	67	39	90
Total - MDW	25 706	2 40	7728	1551	1043	384	8	12	24	17	29	60	52	957	478	2577
																2150

VETERINARY SERVICE

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED DECEMBER 1950
(Data obtained from WD AGO Form 8-134)

STATION	CLASS *	CLASS *	CLASS *	CLASS *	CLASS *	CLASS *	CLASS *	TOTAL
	3	4	5	6	7	8	9	
Fort Leslie J. McNair		79,273	140,177		211,834		79,308	510,592
Fort Belvoir, Virginia		871,685	313,895		1,173,329	104,334	504,678	2,967,921
Alexandria Field Buying Off.		527,014	115,189	612,045			82,018	1,336,266
Fort Myer, Virginia		179,648	171,708	400	370,325	7,340	125,988	855,409
Cameron Station, Alex. Va.		202,280	167,717		375,075	4,502	95,904	845,478
Mil Dist/Washington Vet Det	230,499					259,790		230,499
The Pentagon								259,790
TOTAL	230,499	1,859,900	908,686	612,445	2,130,563	375,966	887,896	7,005,955

REJECTIONS:

Insanitary or Unsound								
Alex. Field Buying Off.								6 6
Mil Dist/Wash Vet Det.	330							330
Fort McNair								105
Not type, class or grade								
Alex. Field Buying Off.			1,701					1,701
Mil Dist/Wash Vet Det.	5,138							5,138
TOTALS	5,468	1,701						6 7,280

*Class 3 - Prior to Purchase
 *Class 4 - On delivery at Purchase
 *Class 5 - Any Receipt except Purchase
 *Class 6 - Prior to Shipment

*Class 7 - At Issue
 *Class 8 - Purchase by Post Exchange, Clubs,
 Messes or Post Restaurants
 *Class 9 - Storage

OUTPATIENT SERVICE

OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, are indicated below for the five - week period ending 29 December 1950:

ARMY:

Number of Outpatients 7152
 Number of Treatments 26667
 NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED
 NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED

NON-ARMY:

Number of Outpatients 7802
 Number of Treatments 23336
 1701
 4789

HOSPITAL MESS ADMINISTRATION

HOSPITAL MESS ADMINISTRATION

STATION	SEPTEMBER 1950	OCTOBER 1950	NOVEMBER 1950	DECEMBER 1950
Fort Belvoir				
Income per Ration	\$1.1591	\$1.1625	\$1.1432	\$1.18
Expense per Ration	.9019	.9538	.9105	1.08
Gain or Loss	+.2572	+.2087	+.2327	+.10

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CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

INDISCRIMINATE ADMINISTRATION OF VITAMINS TO WORKERS IN INDUSTRY

While recognizing the great significance of vitamins in relation to human nutrition and the importance of preparations of vitamins when properly used, the Council on Foods and Nutrition and the Council on Industrial Health of the American Medical Association disapprove of the mass, indiscriminate administration of vitamins to industrial employees for the following reasons: It is unwise nutritionally because special vitamin preparations cannot take the place of valuable natural foods in achieving the completely satisfactory nutritive state. In cases in which there is manifest deficiency disease known to be due to lack of one or more vitamins, and this is not the situation under discussion, the administration of vitamin preparations, in addition, may be called for. Furthermore, in such cases larger therapeutic doses than are given in some industries would be in order. Since for the general run of employees a good diet can provide all that vitamin preparations have to offer and more in this connection, the practice of mass administration of vitamins is uneconomical.

The industrial application of discoveries in preventive medicine and public health has in considerable measure kept pace with the developments in these sciences. Some discoveries have had prompt general application; concerning others there has been a considerable lag. It is generally recognized that the employer should provide hygienic surroundings, proper sanitary facilities, machine guards and the like to decrease accidents. The importance of reducing wherever possible the degree of exposure to poisonous fumes, special chemicals that are harmful in any respect and other noxious substances encountered in industry is widely appreciated. The discovery that the muscle cramps occurring in men working in a hot humid environment with consequent profuse sweating are due to the fact that electrolytes are lost from the body by way of the sweat has led to the practice of supplying sodium chloride to the workers in the industries involved. Some managements have even yielded to sales propaganda and administered cold vaccines to industrial employees in an attempt to reduce absenteeism, particularly in the winter months. It is not surprising, therefore, that there should be much interest in the question whether vitamins should not be administered to industrial workers.

One of the claims advanced centers around the idea of insuring industrial production through what is called "vitamin health control," illustrated by the statement "it is wiser to fortify the rations of employees with required vitamins than allow them to work undernourished." Physicians are of course aware that many factors are required to prevent undernourishment, that vitamins are only a few of those needed. A detailed list of these many factors totals approximately 40, and all of them are readily secured from a good diet of natural foods. Calories are particularly important, and the number of calories required by workers varies directly with the amount of muscular effort expended. No amounts of vitamins and essential mineral nutrients can obviate this need for energy-producing foods. Furthermore, if wholesome natural foods are used as the source of the needed calories, the required vitamins and minerals will be secured automatically, because they are contained in these natural foods.

At least one concern has followed the practice of supplying vitamins to employees (or assisting in this) when the employee's private physician expresses the opinion that this person may be in need of vitamins. In such a situation, obviously, the employee has gone to the trouble to consult his doctor for some reason, and vitamins have come into the picture as a result of that consultation. This situation is, of course, quite different from that in which a concern distributes vitamins indiscriminately to all its employees.

In view of the foregoing discussion the Council on Foods and Nutrition and the Council on Industrial Health conclude that satisfactory evidence of the wisdom of the general practice of industrial concerns providing all their employees with vitamins is lacking. Where a satisfactory study of any given industrial situation indicates the wisdom of supplying vitamins to employees, the Councils wish to point out the necessity for observing the proper scientific limitations of such action in the situation in question; after the employee has been restored to a good nutritive state, the use of a good diet of natural protective foods should then suffice. Nothing in this report is intended to belittle the significance of vitamins in relation to nutrition or the value of the proper use of added vitamins in improving staple foods, such as bread and flour. What is being emphasized is the need to avoid indiscriminate, mass use of vitamins, a practice which supports the commercial exploitation rather than the scientific rational use of these important dietary factors.

Above is abstracted from an article appearing in "Archives of Industrial Hygiene and Occupational Medicine", Vol. 1, No. 5, May 1950, Page 573.

1950 ANNUAL SUMMARY MDW HEALTH STATISTICS

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1950 PREVENTIVE MEDICINE 1951

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GENERAL SUMMARY 1950

Unless otherwise indicated, reference to disease and injuries in this summary applies to all Class I and Class II installations exclusive of Army Medical Center, Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistic presently reported by Army medical installations do not include Air Force personnel. (See page 21)

The annual non-effective rate was 13.14; this was an increase over the 8.19 rate of 1949. During the period the non-effective rate ranged from 6.81 in February to 15.20 in December. A total of 90,375 days lost was reported by units during 1950.

The non-effective rates for 1950 have been computed by charging to each unit the days lost in quarters, as well as days lost on hospital status by each member of their command.

Admissions for all causes during the year totaled 9151 with a resultant rate of 485.7. Of this total, 8318 with a rate of 441.5 for disease and 833 with a rate of 44.2 for injury. Admissions for all causes during 1949 totaled 6653 with a resultant rate of 325.3. Disease accounted for 5922 with a rate of 289.5 and injury 731 with a rate of 35.7. Fort Myer reported the highest rate of admissions with 916.9 per 1000 troops per year. The lowest rate 259.3 was reported by U. S. Army Dispensary, The Pentagon.

The incidence of injuries was 44.2 for 1950, compared to 35.7 cases per 1000 in 1949. Fort McNair reported the highest rate for injuries with 91.2 per 1000 troops per year. The lowest rate 14.3 was reported for U.S. Army Dispensary, The Pentagon. April had the lowest injuries rate with 33.1. The month of December had the highest with 75.8.

A total of 8318 cases of disease with a rate of 441.5 was reported in 1950. This may be compared to 5922 cases with a rate of 289.5 in 1949. Fort Myer reported the highest rate for disease with 834.5 per 1000 troops per year. The lowest rate 245.0 was reported by U. S. Army Dispensary, The Pentagon. During August the disease rate was lowest - 273.4, the highest rate was 703.6 in March.

Deaths among military personnel of Class I and II installations, exclusive of Walter Reed Army Hospital, totaled 16 during the year 1950.

COMMUNICABLE DISEASE

The annual rate of respiratory disease for 1950 was 127.2, compared to 1949 rate of 59.2. The lowest rate was reported in February as 79.9. The month of December had the highest rate with 253.2.

An annual rate of 7.4 was recorded for a total of 140 cases of pneumonia all types. During 1949 there were 161 cases with a rate of 7.9. The highest rate was 14.7 for 26 cases reported in November, and the lowest was .8 for 1 case reported in August.

The annual rate for measles was 7.3, mumps 6.6, tuberculosis .7, rheumatic fever 1.3, diarrheal disease 1.0, hepatitis 1.7 and malaria .3.

There were no cases of scarlet fever reported throughout the year 1950.

Pertinent statistical tables may be found on pages 13 and 21.

1950 PREVENTIVE MEDICINE 1951

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GENERAL DATA

31 December 1949 to 30 December 1950
(Data from WD AGO Form 8-122)

STATION	MEAN STRENGTH			DIRECT ADMISSIONS								Non-Effective Rate	Number of Deaths		
	Total	White	Negro	All Causes		Disease		Injuries							
				Cases	Rates	Cases	Rates	Cases	Rates						
Fort Belvoir, Va.	9557	8215	1342	4996	522.76	4559	477.03	437	45.73	13.65	13				
Fort McNair, Wash. D.C.	855	779	76	352	411.70	274	320.47	78	91.23	11.32	0				
Fort Myer, Va.	1553	1370	183	1424	916.93	1296	834.51	128	82.42	15.46	3				
So Post, Fort Myer, Va.	1693	1690	3	939	554.64	878	599.20	61	35.44	14.14	0				
US Army Disp. The Pentagon	3489	3459	30	905	259.39	855	245.06	50	14.33	14.98	0				
All Others	1691	1690	1	540	319.34	464	274.39	76	44.94	4.27	0				
Total-Military District of Washington	18838	17203	1635	9151	485.77	8318	441.55	833	44.22	13.14	16				

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR

31 December 1949 to 30 December 1950
(Data from WD AGO Form 8-122)

STATION	'Common Respiratory Diseases	Pneumonia All Types	Pneumonia Atypical	Influenza	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Diarrheal Disease	Hepatitis	Malaria	Psychiatric Disease
Fort Belvoir, Va.	141.36	11.82	6.38	.84	14.02	9.21	-	1.15	2.72	.10	2.41	.31	8.48
Fort McNair, Wash. D.C.	69.01	-	-	2.34	1.17	-	-	-	-	4.68	-	-	-
Fort Myer, Va.	218.29	4.51	3.30	175.79	-	5.15	-	.64	-	3.30	2.58	1.29	-
So Post, Fort Myer, Va.	141.76	1.77	1.18	24.22	.59	2.36	-	-	-	.59	2.36	.59	-
US Army Dispensary, The Pentagon	89.42	4.59	4.01	42.99	.29	6.59	-	.57	-	2.01	.29	.29	2.87
All Others	56.77	.59	-	.59	.59	1.77	-	-	-	.59	-	-	-
Total-Military District of Washington	127.24	7.43	4.35	25.21	7.33	6.69	-	.74	1.38	1.01	1.70	.37	4.83

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1950 PREVENTIVE MEDICINE 1951

VENEREAL DISEASE-1950

Incidence of venereal disease for the entire year of 1950 among troops of the Military District of Washington, including Walter Reed Army Hospital, reflected a peak during the month of January followed by a standardization during February, March and April with the low point of a rate of 6 being reported in May. Throughout the remainder of the year the rate fluctuated from a low of 8 in August to a high of 17 in September. With the exception of the month of January the Venereal Disease rate for the Military District of Washington was consistently below the consolidated rate for the continental United States.

Incidence of venereal disease for the Military District of Washington, less Walter Reed Army Hospital, was 13.38 for 1950, compared to 17.41 for 1949 and 18.62 for 1948, this downward trend is noted with interest. Fort Belvoir reported the highest rate with 22.71 and U. S. Army Dispensary, The Pentagon, the lowest with 0.86. The highest rate for the year was reported in January and the lowest rate in May.

Venereal disease incidence among white personnel fluctuated from a high of 17.71 during January to a low of 1.66 for August. Fort Belvoir reported the highest rate for white personnel with 15.34 and U.S. Army Dispensary, The Pentagon, the lowest with 0.87. The white rate for 1950 was 9.24 compared to 10.85 during 1949.

During the month of September the Negro incidence reached its highest rate of 105.40. The lowest rate was reported in May as 24.77. Fort McNair reported the highest rate with 162.94 and U. S. Army Dispensary, The Pentagon, the lowest with no cases reported. The Negro rate for 1950 was 56.88, compared to 83.79 during 1949.

VENEREAL DISEASE RATES FOR US - 1950*

(All Army Troops)

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
First Army Area	12	11	17	11	12	12	16	16	21	14	14	15
Second Army Area	19	21	16	17	14	17	21	18	25	25	17	20
MDW	20	12	11	12	6	10	16	8	17	10	13	11
Third Army Area	26	22	24	27	23	20	24	20	24	23	24	21
Fourth Army Area	21	16	13	11	12	15	14	24	18	17	22	25
Fifth Army Area	16	15	19	13	13	10	13	18	11	14	13	8
Sixth Army Area	20	21	20	21	18	17	17	26	34	18	15	17
TOTAL US	20	18	18	18	15	15	18	20	22	19	17	18

*This information compiled in Office of the Surgeon General and included General Type Hospitals.

OUTPATIENT SERVICE 1950

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, for the 52-week period ending 31 December 1950 are indicated below:

ARMY	NON-ARMY
Number of Outpatients	55,418
Number of Treatments	220,667

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED	17,740
NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED	56,993

1950 PREVENTIVE MEDICINE 1951

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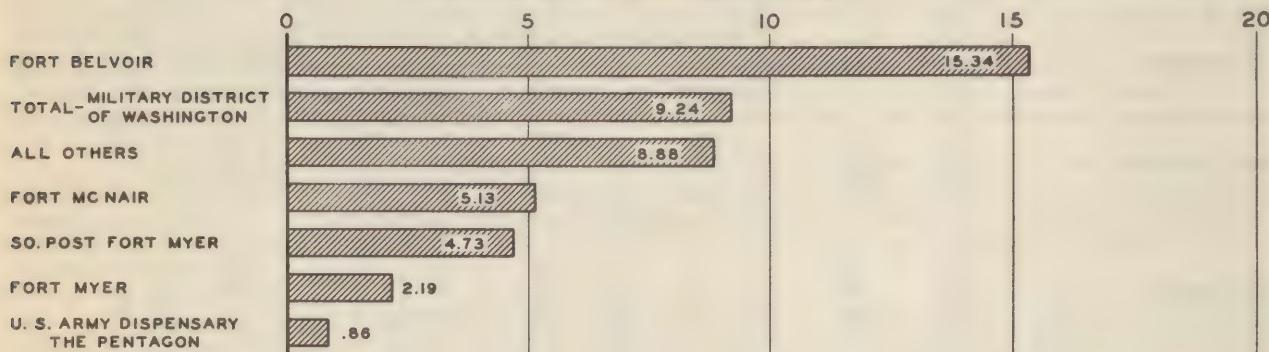
ANNUAL VENEREAL DISEASE STATISTICAL REPORT
31 December 1949 to 30 December 1950
(Data from WD AGO 8-122) (Chargeable Cases)

STATION	R A C E	Mean Strength	Number of Cases-EPTS Not Included				Rate per 1000 Troops per Annum	Total Days Lost From Duty (Old & New Cases)
			Syphilis	Gonorrhea	Other	Total		
Fort Belvoir	W	8215	16	109	1	126	15.34	88
	N	1342	15	75	1	91	67.81	72
	T	9557	31	184	2	217	22.71	160
Fort McNair	W	779	0	4	0	4	5.13	0
	N	76	1	1	0	2	26.32	0
	T	855	1	5	0	6	7.02	0
Fort Myer	W	1370	1	2	0	3	2.19	0
	N	183	0	0	0	0	-	0
	T	1553	1	2	0	3	1.93	0
South Post, Ft. Myer	W	1690	1	7	0	8	4.73	0
	N	3	0	0	0	0	-	0
	T	1693	1	7	0	8	4.73	0
US Army, Dispensary The Pentagon	W	3459	0	3	0	3	.87	0
	N	30	0	0	0	0	-	0
	T	3489	0	3	0	3	.86	0
All Others	W	1690	1	14	0	15	8.88	0
	N	1	0	0	0	0	-	0
	T	1691	1	14	0	15	8.87	0
Total-Military District of Washington	W	17203	19	139	1	159	9.24	88
	N	1635	16	76	1	93	56.88	72
	T	18838	35	215	2	252	13.38	160

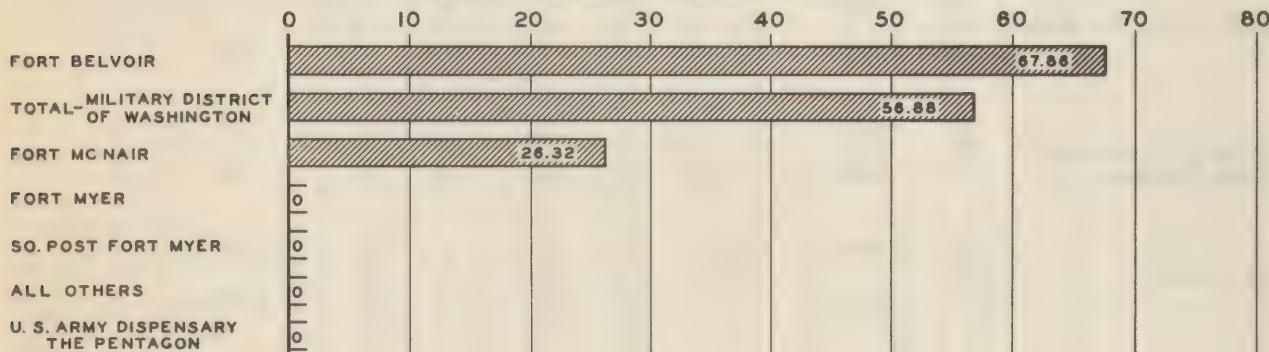
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VENERAL DISEASE
DISEASE RATE PER 1000 TROOPS PER YEAR
31 DECEMBER 1949 TO 30 DECEMBER 1950
WHITE PERSONNEL (CHARGEABLE CASES)



VENERAL DISEASE
DISEASE RATE PER 1000 TROOPS PER YEAR
31 DECEMBER 1949 TO 30 DECEMBER 1950
NEGRO PERSONNEL (CHARGEABLE CASES)



HOSPITAL MESS ADMINISTRATION
(Data from WD AGO Form 8-210)

FORT BELVOIR - 1950

MONTH	INCOME PER RATION	EXPENSE PER RATION	GAIN OR LOSS PER RATION
January	\$1.052	\$1.119	-.067
February	1.057	1.039	+.018
March	1.058	0.980	+.018
April	1.041	1.055	-.014
May	1.026	1.073	-.047
June	1.05	1.14	-.09
July	1.03	1.09	-.06
August	1.1074	1.0177	+.0897
September	1.1591	0.9019	+.2572
October	1.1625	0.9538	+.2087
November	1.1432	0.9105	+.2327
December	1.18	1.08	+.10
Mean (Average 1950)	1.0888	1.0300	+.0588

1950 DENTAL SERVICE 1951

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DENTAL SERVICE - 52 WEEK PERIOD ENDING 31 DECEMBER 1950

STATION	Military		Civilian		Sit- tings	Oxy- and Amal-	Sili- cate	In- lays	Bridges	Bridge Repair	Crowns	Dentures			Extrac- tions	Calcu- lus Removed	X-rays	Examina- tions	
	Men	Duty Days	Men	Duty Days								Full	Par- tial	Re- pair					
Fort Belvoir	8	239	1	20	23530	4281	5856	1949	29	170	61	65	183	244	336	5756	1801	8673	11258
Fort McNair	2	56	1	3	5128	3048	2125	575	12	12	14	22	11	118	36	465	393	1665	1085
Fort Myer, Va.	2	61	1	8	10384	3380	632	596	28	13	16	28	47	171	81	1009	229	6841	3143
South Post Ft Myer	2	44	1	6	3816	2432	900	420	0	2	19	4	23	58	27	370	156	1231	781
US Army, Disp. The Pentagon	6	172	1	16	27878	5867	1774	1758	11	39	96	60	92	229	191	1225	2636	9168	12006
All Others	1	31	0	0	2864	1114	769	386	4	3	5	7	10	42	20	319	127	493	1633
Total - MDW	21	603	5	53	73600	20122	12056	5684	84	239	211	186	366	862	691	9144	5342	28071	29906

1950 VETERINARY SERVICE 1951

CONSOLIDATED POUNDS MEAT, MEAT FOOD AND
DAIRY PRODUCTS INSPECTED YEAR OF 1950

STATION	CLASS *	CLASS *	CLASS *	CLASS *	CLASS *	CLASS *	CLASS *	CLASS *	TOTAL
	3	4	5	6	7	8	9		
Fort Leslie J. McNair		765,523	1,214,255		1,919,206	42,914	491,231	4,433,129	
Fort Belvoir, Virginia		4,187,281	3,560,947		8,451,922	1,025,632	3,020,667	20,246,449	
Alexandria Field Buying Office		5,045,111	1,043,251	6,131,941			860,342	13,080,645	
Fort Myer, Virginia		2,110,599	2,249,927	1,092	4,328,210	88,885	1,612,524	10,391,237	
Cameron Station, Alex. Va.		1,766,248	1,267,397	3,806	2,987,069	64,558	761,989	6,851,067	
Mil Dist/Washington Vet Det.	5,485,972					3,154,848		5,485,972	
The Pentagon									3,154,848
TOTAL	5,485,972	13,874,762	9,335,777	6,136,839	17,686,407	4,376,837	6,746,753		63,643,347

REJECTIONS:

Insanitary or Unsound									
Fort McNair, Wash, D.C.		60				926			986
Fort Belvoir, Va.		328							328
Alex. Field Buying Off.		23,822							26,228
Fort Myer, Va.		1,098							13,107
Cameron Station, Alex. Va.		411							471
Mil Dist/Washington Vet Det	11,168				60				11,168
Not type, class or grade									
Fort McNair, Wash, D.C.		1,037							1,037
Alex. Field Buying Off.		71,258							71,258
Fort Myer, Va.		8,650							8,656
Cameron Station, Alex. Va.		777							777
Mil Dist/Washington Vet Det.	460,611								460,611
TOTALS	471,779	107,441			60	12,912	29	2,406	594,627

*Class 3 - Prior to Purchase

*Class 4 - On delivery at Purchase

*Class 5 - Any Receipt except Purchase

*Class 6 - Prior to Shipment

*Class 7 - At Issue

*Class 8 - Purchase by Post Exchange, Clubs,

Messes or Post Restaurants

*Class 9 - Storage

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Instructions for Denture Patients	March	3	2
Classification of Ice Cream	March	3	4
What is Cancer	March	3	5
Sight Conservation Program	March	3	6
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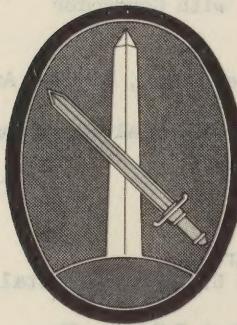
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